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AUTHOR Whitner, Phillip A.; Shetterly, Arminta
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ABSTRACT

The eating disorder known as bulimia is a relatively new and baffling phenomenon. This paper raises questions that college and university counseling center professionals need to address regarding this phenomenon. The first section focuses on defining the term "bulimia" and its evolution. The second section identifies numerous symptoms that need to be evaluated during assessment and diagnosis. Behavioral, physical, personality, and interpersonal and family characteristics of bulimics are listed. The third section is a succinct discussion of treatment modalities, noting that the consensus of opinion is that a comprehensive multidimensional approach or program is desired. It is stated, however, that when the problem is assessed as unidimensional and specific in a given area, a single or noncomprehensive program may be effective. To illustrate the variance in size and scope of treatment strategies, a few examples of programs are given. The fourth section raises issues which college and university counseling center professionals need to address, including whether college and university counseling centers should treat clients with bulimia. The paper concludes with a brief summary statement. References are included. (TE)

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BULIMIA

Issues A University Counseling Center Needs To Address

Phillip A. Whitner

and

Arminta Shetterly

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A paper presented at the annual American Association for Counseling and Development national conference in Cincinnati, Ohio, March 16-19, 1990.

University Counseling Center
The University of Toledo
(419) 537-2426

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BULIMIA

Issues A University Counseling Center Needs To Address

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and

Arminta Shetterly

University Counseling Center
The University of Toledo

The eating disorder known as bulimia is a relatively new and baffling phenomenon. The intent of this paper is to raise questions that college and university counseling center professionals need to address regarding the phenomenon. The paper is divided into five sections. The first section focuses on defining the word, or term, bulimia and its evolution. The second section identifies numerous symptomatic areas that need to be evaluated during assessment and diagnosis. In the third section, treatment modalities are succinctly discussed. The fourth section raises issues which college and university counseling center professionals need to address. The paper concludes with a brief summary statement.

INTRODUCTION

The word Bulimia comes from the Greek word which means "the hunger of an ox" (Webster's New..., 1975). The following definitions of bulimia have appeared in published American dictionaries during the past few years:

1985 ... "abnormal and constant craving for food" (Webster's Ninth..., 1985).

1982 ... "insatiable appetite" (The American Heritage..., 1982).

1980 ... no definition listed (Oxford American..., 1980).

1975 ... "an abnormal and constant craving for food" (Webster's New..., 1975).

1958 ... "excessive appetite for food" (A Comprehensive..., 1958).

During the last two decades, according to Johnson and Connors (1987), there has been a proliferation of reports describing pathological eating behaviors. The authors state, "The term bulimia, virtually unknown several years ago, has become familiar both to professionals and to the public...early research has facilitated our understanding of the disorder, it has also spawned confusion and controversy over nomenclature, criteria for diagnosis, etiology, and treatment" (p. 3).

To illustrate the recent past meaning of the term bulimia, Calhoun (1977, p. 409) says, "...the most common developmental disorders are the habit disturbances --- that is, disruptions of the child's most natural functions, such as eating, sleeping, and toileting." Three feeding disturbances --- bulimia, anorexia nervosa, and pica --- are discussed by the author who says that

bulimia is excessive overeating that results in obesity. Calhoun states that Hilde Bruch:

> ...one of the leading theorists on obesity, distinguishes three different, though not mutually exclusive, categories of obesity. First, a child may become obese not because of any emotional problem, but because overeating is the "normal" thing to do in his family and in his ethnic group. Second, obesity may occur in response to some acute emotional stress (e.g., the death of a parent or the birth of a sibling), and in this case may function as a form of consolation and reassurance. Third, obesity may occur as a function of family problems, and especially of marital problems between the parents. When parents are in conflict with each other, they often attempt to satisfy their own needs through their children. The response of the mother, in particular, may be to overprotect and overfeed the child. As a result, the child becomes obese and maintains his obesity by overeating whenever he is subject to stress and frustration. (p. 409)

The eating disorder bulimia has a snowball effect (Calhoun, 1977). An obese child is a child who is ridiculed, which leads to feelings of guilt, rejection, and self-contempt, which leads to the exclusion from peer-group relationships and activities. These feelings and exclusions become sources of further stress, which leads the child to overeat or binge eat even more than before. These binges are the rapid uncontrolled consumption of large amounts of food. Binges may last from a few minutes to several hours and the number of calories consumed may range from 1,000 to 55,000. Purging is the act of getting rid of food eaten during a binge. The most common method of purging is self induced vomiting. Laxatives, fasting, severe diets, and vigorous exercise are other methods used by individuals to counteract a binging episode (Agras, 1987; Kirschenbaum, Johnson & Stalonas, 1987; LeBow, 1989; Weiss, Katzman & Walchik, 1985).

The behaviors of binge eating and purging are never mentioned by Calhoun (1977) when he discusses bulimia. However, in his discussion of the eating disorder anorexia nervosa he says the "...disorder can take one of two forms: the patient refuses to eat, or she eats and then either induces regurgitation or regurgitates involuntarily" (p. 148).

Bruch (1985) provides an overview of how the phenomena of eating disorders has evolved during the past four decades and then discusses the confusion which surrounds the disorders today. She believes that eating disorders reflect the interaction of biological, psychological, and sociological factors which work in close concert and that it is not always possible to keep these factors separate. Bruch's interest in fat children represented her entrance into the field of psychiatry. As time passed, however, fat children's appeal was surpassed by their clinical counterpart, the sufferers of anorexia nervosa --- individuals who starve themselves. Bruch says that anorexia nervosa "...was so rare in the early 1940s that it was practically an unknown disease, though physicians had heard about it in medical school" (p. 8).

Bruch's (1985) first published paper was in 1961. The paper "...was based on observation of 12 anorexia nervosa patients, then a relatively large number...Since the late 1950s, the incidents have rapidly increased. No reliable figures are available about the actual frequency" (p. 9). Explanations for the increasing number of anorexic patients are only speculative. Bruch says:

> The common argument points to the cultural emphasis on increasing slenderness as the determining factor. In my

> opinion, this does not do justice to the psychological complexity of the disorder, which reflects a much more severe disturbance than dieting out of control. Normal weight control is distinctly different from the frantic preoccupation with excessive slenderness of the anorexic. My own observations suggest that the changing status of (and expectations for) women plays a role. Girls whose early upbringing has prepared them to become "clinging vine" wives suddenly are expected at adolescence to prove themselves as women of achievement. This seems to create severe personal self-doubt and basic uncertainty. In their submissive way, they "choose" the fashionable dictum to be slim as a way of proving themselves as deserving respect. (p.9)

A specific syndrome which Bruch (1985) identifies and names "primary anorexia nervosa" can be differentiated from unspecific forms of psychologically determined weight loss. Unspecific forms of weight loss are secondary to other psychiatric illness, such as hysteria, schizophrenia, and depression. Primary anorexia nervosa is characterized by severe weight loss, severe body image disturbances, inaccurate identification of body and emotional states, and an all-pervasive sense of ineffectiveness. Bruch elaborates by saying:

> Primary anorexia nervosa affects mainly adolescent girls and young women from educated and prosperous homes; it occurs only rarely in the male, usually in prepuberty. An important new finding was that patients with primary anorexia nervosa do not suffer from loss of appetite; on the contrary, they are frantically preoccupied with food and eating. In this they resemble other starving people. Relentless pursuit of thinness seems to be the outstanding symptom, and in this pursuit they deliberately --- seemingly willfully --- restrict their food intake, and overexercise. It is of interest that the German name for the condition is Pubertaets Magersucht, or addiction to thinness. These girls are panicky with fear that they might lose control over their eating; when they do, they will gorge themselves on often unbelievably large amounts, which they vomit afterward. Anorexics have also been found to be uncertain in identifying hunger or satiety, and they use eating, or

> refusal to eat, for the pseudosolution of personality difficulties and problems of living. It was also recognized that the basic illness is not a disturbance of the eating function, though the physical and psychological consequences of the severe malnutrition dominate the manifest clinical picture; the deeper psychological disorder is related to underlying disturbances in the development of the personality, with deficits in the sense of self, identity, and autonomy. Needless to say, there are numerous disturbances in sexual maturation and gender identity; these are part of the larger maldevelopment and are not of any specific etiological significance. (p. 9-10)

Anorexia nervosa, according to Bruch (1985) represents an illness in its own right because the psychological and the somatic factors closely interact. She says, "The rigid discipline over their eating, with the visible weight loss, gives them the experience of being effective and in control in at least one area. The displayed defiance is not an expression of strength and independence, but a defense against the feeling of not having a core personality of their own, of being powerless and ineffective when they give in" (p. 10). Psychiatrically, the disorder appears to be more akin to borderline states --- narcissism or schizophrenia --- than to neurosis.

The patients that were seen during the 1950s and 1960s, according to Bruch (1985), had in common that each was an original inventor of his/her own symptoms and reactions. This originality gave to the behavior of each individual patient an aura of superhuman discipline and special power. Once anorexia nervosa became more frequent, some changes seemed to have occurred. Bruch says that anorexics:

> ...who developed the illness during the 1970s often had "known" about the illness, or even knew someone who had it. During the past few years several patients deliberately "tried it out" after having watched a TV program or having assembled a science project. There is no doubt in my mind that this "me-too" picture is associated with changes in the clinical --- in particular, the psychological --- picture; I am not yet able to define them, except that something like "passion" has gone out of the picture. Instead of the fierce search for independence, these new "me-too" anorexics compete with or cling to each other. That they seek support in self-help groups or respond to the various "programs" that have sprung up all over the country may be an illustration of the development. The desire to be special, unique, or extraordinary is expressed with less vigor and urgency, and I cannot suppress the suspicion that in some the symptoms are imitative or faked. It is my feeling that ultimately the condition will lose its specific psychodynamic meaning. As it becomes more commonplace, the picture will become blurred and gradually disappear until the conditions are right again for genuine primary anorexia nervosa. (p.11)

Johnson and Connors (1987, p. 7) say that "...prior to the 1940s bulimic behavior was reported as occurring primarily in the context of anorexia nervosa. During the 1950s the phenomenon of binge eating was described among obese populations. It was not until the last decade, however, that the prevalence of bulimic behavior among individuals without significant histories of weight disorder became apparent." Bulimia, according to Bruch (1985), is a symptom of the disordered eating phenomenon. She discusses bulimia and its relationship to what she has named "primary anorexia nervosa". Bruch says:

Not all anorexics are able to maintain rigid control over their eating. When they give in to their desire for food and gorge themselves, they will devour huge amounts of food. Subsequently, they will vomit and thus maintain the low weight. About 25% of the group on which I reported in 1973 in Eating Disorders showed this symptom. The anorexics who would binge did not look too different from the abstainers, though they appeared to be less rigid and emotionally somewhat more alert, but also more disturbed. During the last 5 to 10 years, binge eating has occurred more often --- in more than 50% of the recent cases. There is agreement that it makes treatment more difficulty and presents a dangerous complication.

During the past few years, bulimia has made its appearance as the great new eating disorder. It appears in the Diagnostic and Statistical Manual of Mental Disorders third edition (DSM-III), but is mainly discussed in the media and popular press. It is presented as closely related to anorexia nervosa; someone has even invented a semantic atrocity, "bulimarexia" as if to indicate that the two conditions are nearly identical, which they are not, or as if they occur in the same person. I have grave doubts that bulimia is a clinical entity. Compulsive overeating may occur in different conditions and with different severity.

The patients with bulimia whom I have studied bear little resemblance to those with genuine anorexia nervosa...They make an exhibitionistic display of their lack of control or discipline, in contrast to the adherence to discipline of the true anorexics, even those with eating binges.

Many bulimics will vomit after overeating to avoid weight gain as a consequence. The modern bulimic is impressive by what looks like a deficit in the sense of responsibility. Bulimics blame their symptoms on others; they may name the persons from whom they "learned" to binge, in particular those who introduced them to vomiting. Often this has occurred in a single episode, but from then on they act like completely helpless victims. Though relatively uninvolved, they expect to share in the prestige of anorexia nervosa. Some complain about the expense of their consumption and will take food without paying for it. They explain this as due to "kleptomania," which indicates, like "bulimia," an irresistible compulsion that determines their behavior. To consider them part of the anorexia nervosa picture confuses instead of clarifying the issues. (p. 11-12)

A key to reducing confusion and clarifying the disordered eating phenomenon is an understanding of bulimia. Does bulimia mean to gorge or binge eat? Or, does bulimia mean to binge eat and purge? Or, does bulimia mean severe psychological disturbances, accompanied by binge eating and purging behavior? At this point, it may be worth noting that the original definition of bulimia may have taken on too many meanings. Or, it just may be that some professionals assumed their colleagues were familiar with the eating disorder language and used the terminology the same as themselves. Or, it just may be that new and important information was at hand, but relating it to the overall eating behavior phenomenon, or placing it in the proper perspective was not achieved.

Nevertheless, we are where we are today, which raises the question, "Is defining bulimia important?" Hill (1989) demonstrated in her study that a change in the definition of bulimia can reduce or increase its prevalence. However, the bulimic symptoms persisted at the same rate. Table 1 graphically portrays the global references that have been made regarding bulimia and illustrates its pervasiveness in the overall picture. A number of definitions with their original sources appear in Appendix A and will aid when viewing Table 1.

TABLE 1: A PERSPECTIVE OF BULIMIA

PRIMARY ANOREXIA NERVOSA

WEIGHT

LOW

CHARACTERISTICS

* severe weight loss
* severe body image disturbances
* inaccurate identification of body and emotional states
* an all-pervasive sense of ineffectiveness

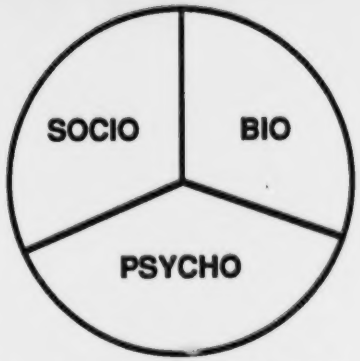
* Bulimic Anorexic (Johnson & Connors)
* Bulima Nervosa (Russell)

DMS - III — Bulimia Nervosa — DMS - III - R

1980 (+) prevalence (-) 1987

Binge & Purge

SECONDARY WEIGHT LOSS

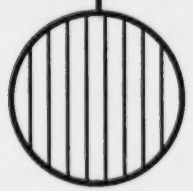


* Abnormal/Normal Weight Control Syndrome
* Dietary Chaos Syndrome
* Bulimarexia

OBESITY

WEIGHT

HIGH



* Bulimia
* Stuffing Syndrome
* Binge Eaters

KEY

* Abnormal Normal Weight Control Syndrome (Crisp, 1981)
* Binge Eaters
* Bulimarexia (Boskin-Lodahl, 1976)
* Bulimia (original dictionary definition)
* Bulimia Nervosa (Russell, 1979)
* Bulimia Nervosa (DMS - III 1980)
* Bulimia Nervosa (DMS - III - R, 1987)
* Bulimic Anorexic (Johnson & Connors, 1987)
* Dietary Chaos Syndrome (Palmer, 1979)
* Stuffing Syndrome
* BIO - Biological
* SOCIO - Sociological
* PSYCHO - Psychological

SYMPTOMS

A review of the literature quickly reveals the lack of clarity and confusion that surrounds the eating disorder phenomenon. This confusion grows out of the newness of eating disorders as well as their complex nature. At the very least, bulimia is now generally seen as a multifaceted disorder which normally includes maladaptive behavioral patterns, psychopathology, and disordered family and interpersonal patterns. The following is a listing of symptoms or characteristics of the bulimic which have been identified in the literature. The symptoms are not rank ordered in degree of importance and the list in not all inclusive.

Behavioral Characteristics

* use of laxatives or diuretics
* strict dieting or fasting
* avoidance of sweets and carbohydrates except during binges
* increased sexual activity and interest as compared to anorexics
* binge eating
* self induced vomiting
* vigorous exercise
* numerous attempts to diet

Physical Characteristics

* majority within normal weight range
* 90% are females
* nutritional deficiencies
* electrolyte imbalances (leads to cardiac arrest, tiredness, and depression)
* menstrual irregularity
* many have acute medical complications
* 86% between age 15-30
* dental cavities
* irritation and ulcerations of esophagus
* edema

Personality Characteristics

* feels ineffective
* high expectations
* distrusting of others
* high levels of pathology on MMPI
* exaggerated guilt
* poor differentiation of sex role
* self rejecting
* characterological problems
* dichotomous thinking (all good or all bad)
* egocentric (everyone evaluates them)
* social isolation
* low self-esteem
* high self-criticalness
* self hating
* dissatisfaction with body size
* chronic depression
* poor identification of internal state
* poor impulse control
* low frustration tolerance
* food has control over them
* poor life adjustment
* borderline personality

Interpersonal and Family Characteristics

* impaired social relations and daily activities
* parents high levels of neurotic maladjustment, obesity, and physical illness
* family expresses little support
* family experiences a lot of conflict
* family encourages dependency
* family disengaged and hostile
* family does not openly express feelings

TREATMENT

The treatment of disordered eating behaviors is varied. However, the consensus of opinion is that a comprehensive multidimensional approach or program is desired. This is not to say that a single approach or a small narrowly focused program is ineffective. On the contrary, if the problem is assessed and diagnosed as unidimensional and specific in a given area, a single or noncomprehensive program may be ideal. Treatment strategies and programs vary in size and scope. To illustrate their variance, a few examples are provided.

According to Etringer, Altmaier, and Bowers (1989), counselors need to be aware of the cognitive functioning of bulimic women. These investigators reported that "...present data appear to indicate robust differences in the cognitive functioning of bulimic and non-bulimic women" (p. 219). Etringer, Altmaier, and Bowers suggest that counselors may find that engaging their clients to work directly with problem-solving skills, expectations for success, and attributional styles may be extremely effective counseling adjuncts for bulimic women.

A treatment program for a nonsevere eating disorder population has been developed by Heretick (1986). Prior to program entrance, the client makes the arrangements for an independent medical examination and a medical history to be forwarded to the program coordinator. After assessment and evaluation, a decision is made to accept the client to the program or refer to other treatment sources for assistance. If accepted, the client is provided

options to engage in individual, family, or limited group therapy -- or become involved in all. In addition, the client is encouraged to participate in one and two day program retreats.

A residential facility for the exclusive treatment of anorexia nervosa and bulimia was opened in 1985. The Renfrew Center (Levitx, 1989), which is located on 27 secluded acres on the northwest edge of Philadelphia, provides individualized comprehensive treatment programs for each resident. The Center has more than 50 specialized clinicians who implement a seven to nine week individualized treatment program. The Center has been approved by the Joint Commission on the Accreditation of Hospitals.

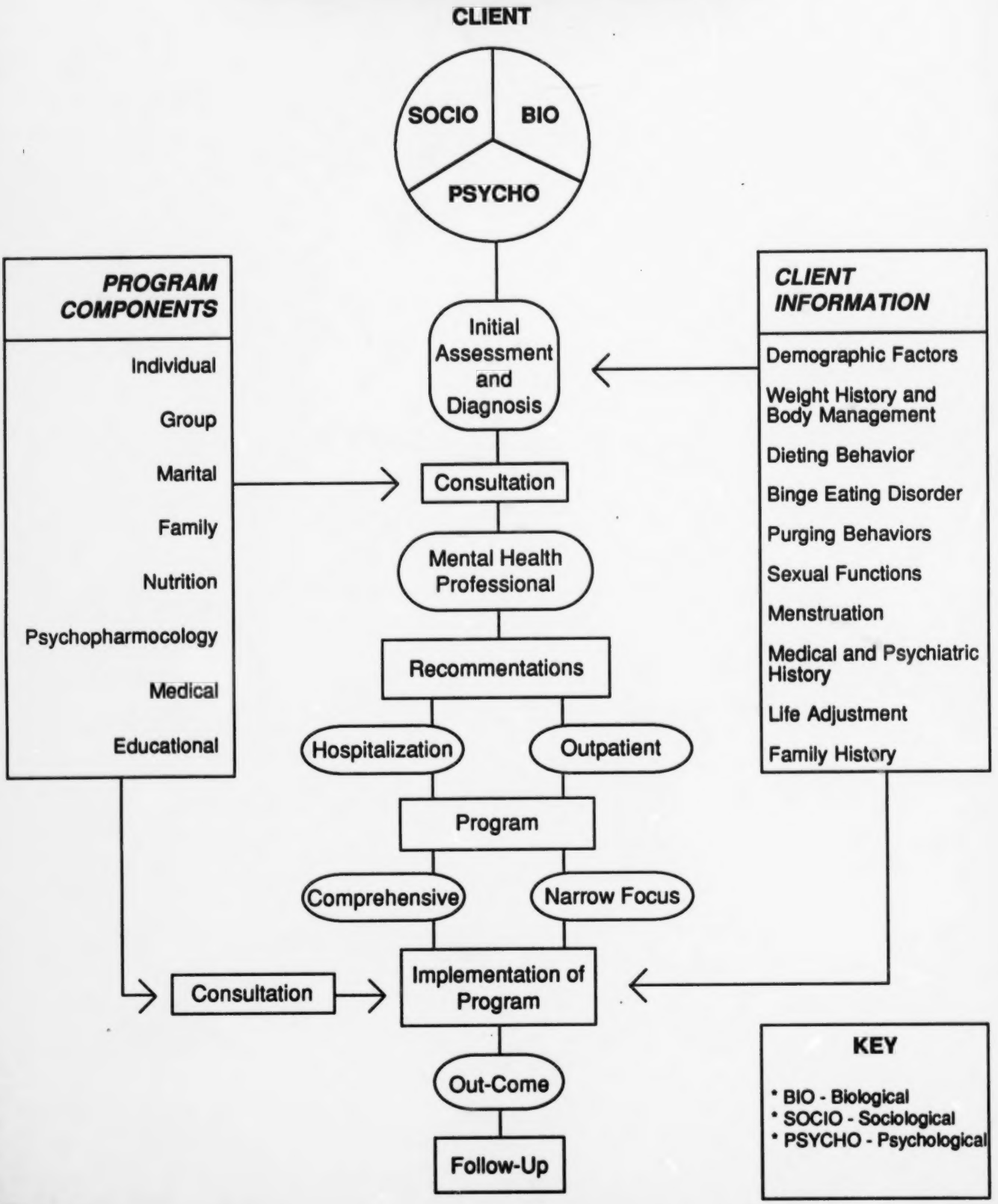
Outcome and follow-up research support the validity of a unique approach, or program, to the treatment of bulimic women. The Intensive Treatment Program (Wooley & Lewis, 1989), utilizes the interlocking roles of individual, family, group, and body image therapy. The program is a four week residential out-patient program that accepts women from throughout the country. Groups, which consist of eight clients, simultaneously begin the program. The clients reside in apartments in a nearby hotel where they are responsible for their own food preparation. The clients attend the program's clinic 6 to 8 hours each weekday for therapy. The six components of the Intensive Treatment Program are food group, educational seminars, psychotherapy group, body image group, individual therapy, and multifamily group. A premise of the program is, "The great tragedy of bulimia is not that the patient's attempt to perfect her outer appearance fails, but that it

succeeds. The unsightly tangle of repressed human needs and feelings is ultimately so well concealed that even she can no longer see it. In the uncovering of this real self, the missing woman is found" (p. 82).

Two comprehensive treatment approaches of disordered eating behaviors have appeared in the literature (Garner & Garfinkel, 1985; Johnson & Connors, 1987). The approaches, or programs, emphasize the impact that biological, psychological, and sociological factors have had in the development of eating disorders. Both programs have a rigorous assessment and diagnostic phases and include individual therapy, group therapy, marital therapy, family therapy, nutrition education, psychopharmacology, and medical evaluation and treatment as major rehabilitation components.

The treatment of eating disorders is complex and diverse. However, there are major treatment areas and components of which mental health professionals need to be extremely cognizant. These areas and components are critical and their import needs to be explored and evaluated during the initial phases of treatment. Table 2 depicts some of these major treatment areas and components.

TABLE 2: TREATMENT



ISSUES

Should college and university counseling centers treat clients or students with bulimia? If so, what are the minimum staff resources, knowledge, and training that are needed? What specialized facilities may be necessary? Can counseling centers justify the length and cost of treatment? If multimodal therapy is the most effective, how are the different disciplines and team members interfaced with each other? Can families be expected to participate in treatment, given the long distances some must travel? How are issues of confidentiality handled, especially when other treatment disciplines must be consulted or families informed because of reimbursement policies? And finally, what do counseling centers do when the bulimia significantly interferes with the student's academic progress or living arrangements? These are some of the questions which need to be thoughtfully addressed when counseling center professionals are considering whether they should or should not provide treatment for bulimia. The following are issues which professionals need to consider when seeking answers to the above questions.

Because of the complexity of both the symptom pattern and the psychological problems of the bulimic individual, counseling centers need to employ professionals with advanced diagnostic skills who can assist in the assessment and diagnostic phases of treatment. The first section of this paper points to the muddled

and often confusing criteria for the diagnosis of bulimia. At the very least, the counselor needs to be aware of the behavioral patterns, personality configurations, and family dynamics that typify the bulimic. This awareness may require specialized skill development in addition to the advanced training of a profession such as social work, psychology, psychiatry, or counseling. This need for sophistication demands that counseling center professionals identify the training needs or the specialized skills required before embarking on treatment.

If counseling center professionals make the decision to provide treatment for bulimics, what type of treatment will be offered? Most standard treatment programs include professionals who possess mental health, medicine, and nutrition credentials. Do college and university counseling centers have these professionals readily available to provide treatment? If so, are the available professionals trained to meet the special needs of this population? And, if resources are scattered across the campus, who would be responsible for coordinating the treatment services? Traditionally, college and university counseling centers are separate facilities from health care centers, which is where the medical and psychiatric personnel are housed. Also, if nutritionists need to be consulted, they may be employed on yet another part of the campus. In general, nutritionists have little or no contact with either the counseling center or the health care center. It is probably the unusual college or university that has the necessary space and facilities available to bring all the

professionals together in a cooperative effort to implement a treatment program for bulimics.

If it is not possible to assemble all the ingredients for an effective treatment program, referral to outside sources may be necessary. Most outside sources require reimbursement, which means the bulimic individual may have to inform family members of his/her problem. The student often comes to the counseling center only because of the assurance of confidentiality. If the student needs to be referred, who informs the parents if the student refuses to do so? If the student refuses to inform parents, and there are obvious health dangers, are counselors justified in breaking confidentiality?

Most college and university counseling centers use short-term treatment modalities as their primary service. Research indicates that treatment for bulimia is long-term and generally lasts for months or years. Are counseling centers prepared to commit their staff to long-term treatment? The cost in counseling center staff time plus the expense generated by multi-disciplinary involvement certainly must be considered when deciding to treat bulimia.

Logistical problems can also arise when a multi-disciplinary team approach is involved in treatment. Problems could include: scattered treatment sites; coordination of services; monitoring of services; schedule conflicts for both client and treatment team members; student dissatisfaction and confusion; academic disruption; and coordination of follow-up.

Lastly, another consideration is the role of the counseling center vis a vis other departments at the university. If the bulimic behavior is disruptive to living situations and the student is directed to seek treatment by residence hall staff, should the counseling center force treatment on this student? Would this undermine treatment from the beginning? What if the bulimia significantly interferes with the student's academic progress? Should the counseling center approve or be involved in the sanction of medical withdrawals? Should counselors encourage students to remain in school when they are experiencing difficulty? What should the role of the counselor be in explaining the student's situation to instructional staff who questions the legitimacy of the student's problem?

In summary, the above areas are some of the issues counseling center professionals need to address thoughtfully before implementing a bulimia treatment program. Otherwise, the counseling center staff may find themselves unprepared to provide adequate services or to make appropriate referrals.

CONCLUSION

In the first section of this paper the word bulimia was scrutinized and its relationship to the eating disorder phenomenon was examined. The second section listed numerous symptomatic areas of the disorder. Some treatment modalities were presented in the next section and issues relevant for college and university counseling center professionals followed in the fourth section.

It is apparent that eating disorders are extremely complex. Bulimia per se appears to be a symptom of more pervasive problems. Mental health professionals need to have a basic understanding of the eating disorders phenomenon so they can identify the expertise that is required for treatment.

Appendix A

DEFINITIONS

The following descriptive definitions and their original sources have been adapted from Garner and Garfinkel (1985), and Johnson and Connors (1987).

Primary Anorexia Nervosa (Bruch, 1985)

- severe weight loss
- severe body image disturbances
- inaccurate identification of body and emotional states
- an all-pervasive sense of ineffectiveness

Bulimarexia (Boskin-Lodahl, 1976)

Identified the symptoms of bulimia among a predominantly normal weight population of over one hundred adult college women who responded to an advertisement in a campus newspaper. The advertisement was for women who were caught in a "cycle of gorging on food and then purging by habitual forced vomiting, severe fasting, or laxative or amphetamine abuse." Boskin-Lodahl noted:

- most respondents were of normal weight
- attitudinally, they were very similar to anorexia patients:
    - they felt helpless
    - they had distorted body images
    - they were extremely fearful of being fat

However, respondents did not appear to be as psychologically disturbed as anorexia nervosa patients. Unlike anorexics:

- they were able to continue demanding university work
- they did not require hospitalisation
- they were insightful enough to seek treatment about their eating problems

Bulimia Nervosa (Russell, 1979)

- patients suffer from powerful and intractable urges to overeat
- they seek to avoid the fattening effects of food by inducing vomiting or abusing purgatives or both
- they have a morbid fear of becoming fat

Bulimia Nervosa (DMS-III, 1980)

- recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours)
- at least three of the following:
  - consumption of high-caloric, easily ingested food during a binge
  - inconspicuous eating during a binge
  - termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting
  - repeated attempts to loose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics
  - frequent weight fluctuations greater than ten pounds due to alternating binges and fasts
- awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.
- depressed mood and self-depreciating thoughts following eating binges
- the bulimic episodes are not due to Anorexia Nervosa or any known physical disorder

Dietary Chaos Syndrome (Palmer, 1979)

Predominantly normal weight individuals who exhibit symptoms of bulimia.

Descriptive report (Pyle, Mitchell & Eckert, 1981)

A clinical population of thirty-four patients who were without previous histories of anorexia nervosa and were reported to be experiencing significant psychological distress as a result of bulimia.

Descriptive reports (Fairburn & Cooper, 1982) (Johnson, Stucker, Lewis, & Schwartz, 1982)

Separate reports which used large mail samples from readers of popular women's magazines. The studies provided the first data-base that bulimic behavior was highly prevalent among adolescent and young adult women.

Abnormal Normal Weight Control (Crisp, 1981)

Predominantly normal weight individuals who exhibit symptoms of bulimia.

Bulimic Anorexic (Johnson & Connors, 1987)

- a greater frequency of higher premorbid body weights
- significant affective instability resulting in various impulse dominated behaviors
- a tendency toward more severe life impairment resulting in less improvement over time

Bulimia Nervosa (DMS-III-R, 1987)

- Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time)
- A feeling of lack of control over eating behavior during the eating binges
- The person regularly engages in either self-induced vomiting, use of laxatives or diuretics, strict dieting or fasting, or vigorous exercise in order to prevent weight gain
- A minimum average of two binge eating episodes a week for at least three months
- Persistent overconcern with body shape and weight

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